EC

GOVERNOR'S TASK FORCE ON TEEN PREGNANCY

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I. INTRODUCTION AND PURPOSE

In February, 1984, Governor Hughes appointed a task force to study the issue of teen pregnancy in Maryland. Dr. John B. Slaughter, Chancellor of the University of Maryland, College Park, agreed to chair the Task Force on Teen Pregnancy which was charged by the Governor to:

- Examine the issue of teen pregnancy in Maryland;
- Explore the current level of services offered by public and private agencies in the state;
- Identify gaps in the coordination and delivery of services;
- Recommend a comprehensive approach to reduce the incidence of teen pregnancy and to help teen-aged parents and their children to become self sustaining.

Dr. Slaughter has outlined a plan of action for the Task Force which culminates in the presentation of a final report to Governor Hughes in June 1985. The purpose of this interim report is three-fold. First, it is a status report which summarizes the extent and consequences of teen pregnancy in the State. Secondly, the plans and strategies for carrying out the mission of the Task Force are outlined. Finally, the report includes some preliminary observations and recommendations.

II. EXTENT OF TEEN PREGNANCY IN MARYLAND: THE CONTEXT FOR THE TASK FORCE

The Task Force is in the process of developing a comprehensive understanding of the extent of teen pregnancy in Maryland; however, sufficient data are presently available to profile the general nature of the problem.

Live Births:

There were 8,771 registered live births in Maryland delivered to women under 20 years of age in 1983, the second lowest number recorded since 1970. Although this number reflects a decrease over the number of births to this group since 1970, the downward trend in the number of births observed between 1970 and 1978 has not subsequently occurred. There was essentially no difference in the number of 1978 and 1983 births to this age group.

Despite the decline in live births observed since 1970, women under 20 years of age continue to account for a significant number of births in the State. In 1983, births to teenagers represented 13.7 percent of all Maryland births.

There are dramatic differences in childbearing patterns when age and race of teen mothers are considered. The number of births occurring to women under 17 years of age has been consistently higher among non-whites than whites. This difference between racial groups is greatest among teens under 15 years of age. For example, in 1983, there were 161 births to non-white teens under age 15 and 36 births to white women in the same age group, that is, a ratio of 4.5 to 1.0. The pattern is reversed, however, when considering women between the ages of 18 and 20 as well as older women where white women, who make up the majority of the population in all age groups, bear the majority of babies.

Birth Rate by Age and Race

Declines in the birth rate, that is, the number of live births per 1,000 population, have also been observed during the last 14 years. These changes occurred mainly among the teens, aged 15-19, regardless of race, but were most pronounced among the non-white population. It is only among whites under the age of 15 that birth rates have been resistent to decline, and in fact, have risen.

Abortion

A substantial number of Maryland teenagers have opted to abort their pregnancies over the last 14 years. Unlike live births, abortions performed on Maryland residents outside of the state boundaries, are not reflected in the figures being reported. Abortion figures are likely, therefore, to be underestimates of the actual incidence. The abortion ratio, that is, the number of abortions per 100 live births, has risen, largely as a function of the abortion rate among the youngest teenagers. Since 1973, more women under the age of 15 have chosen to terminate their pregnancies than to carry them to term. Among this age group, white teens are more likely to voluntarily terminate their pregnancies by abortion than are black teens; and this pattern has been consistent over the last 14 years. Abortion ratios are also higher for whites than blacks among 15-19 year olds. This pattern is reversed among older age groups; and the likelihood of abortion is higher among older black women than their white counterparts.

The full impact of abortion, both spontaneous and induced, on teen fertility is apparent when pregnancy rates are compared. Pregnancy rate refers to the total number of pregnancies regardless of pregnancy outcome. Therefore, pregnancy rate reflects the total number of live births, induced

and spontaneous abortions and fetal deaths per 1,000 women of comparable age. Comparisons of pregnancy rates for data years 1976 and 1981 show that for the State as a whole, the pregnancy rate increased by about ten percent. Despite declines in the absolute number of births to young Maryland residents, teenage pregnancy rates remain substantially high.

Marital Status

Of those teenaged Maryland residents who bore children since 1970, an ever increasing number delivered their babies out-of-wedlock. There were 6,286 births to unmarried teenaged women in Maryland in 1983 accounting for 72% of all births to women under age 20. This is an increase over the previous year. In fact, the percentage of out-of-wedlock births has risen steadily since 1970. Pregnant white women of all ages are more likely to be married than are their black counterparts, although the differences by race are declining. The proportion of out-of-wedlock births among young white teenagers accounts for the greatest age-specific increase in the State over the last decade. The gap between the races in the percentage of unmarried widens for women between the ages of 15 and 24, and then begins to narrow for older mothers. Regardless of race, however, the younger the woman at the time of childbirth, the greater are the chances she will give birth outside of wedlock, and conversely, the older the woman, the more likely she will be married.

A caveat must be noted regarding the derivation of statistics on marital status. Beginning 1980, Maryland became one of nine states in the United States lacking a direct reference to marital status on the birth certificate. Instead, marital status is inferred from a comparison of the child's and parents' surnames. Although this procedure may misrepresent marital status among women who chose to retain their maiden name, this practice is uncommon among teenagers and should not significantly inflate the figures being reported.

Infant Mortality and Low Birth Weight

Among the risk factors associated with early childbearing are high infant mortality and a high incidence of low birth weight deliveries. In the most recent three year period for which data are available, the infant mortality rate, that is, the number of infant deaths per 1,000 live births, was substantially higher among women aged 10 to 14 years than any other age group. During 1970-81, approximately 137 of every 1,000 infants born to Maryland women 10 to 14 years old, died. The second highest infant mortality rate occurred among women aged 15 to 19 for whom 18.9 infant deaths were reported per 1,000 births. The infant mortality rate among the younger white mothers exceeded that of their black counterparts, while among the older teens, black mothers were more likely to lose their infants.

Babies weighing 2,500 grams or less account for a disproportionate number of births to women under age 19. Birth weight is linked to the timing of prenatal care and 40-50 percent of Maryland teenagers, like their counterparts throughout the country, delay care until the second or third trimester. Black women and younger women are more likely to delay care than are white women and older women.

Similarly, other sociocultural variables such as poor nutrition and poverty are predictive of low birth weights. These variables are likely to contribute to the incidence of low birth weight deliveries among Maryland teenagers as well.

Medicaid and Aid to Families with Dependent Children (AFDC)

Of the 8,771 births to Maryland teenagers in 1983, Medical Assistance paid for the expenses of almost half. More specifically, birth related expenses associated with 912 births to women under age 18 and 3,304 births to women 18 and 19 years old were paid for by Medical Assistance. Clearly, teenage deliveries account for a significant proportion of publically funded births.

Nationally and locally, mothers and children in AFDC families were younger than in previous years. In Maryland, it is estimated that about 13,000 teen parents under the age of 21 received AFDC grants during the period July 1, 1982 to June 30, 1983 and of these about 7,000 were under the age of 18. During this period, the average AFDC family (one adult and 1.77 children) in the State received less than $200 per month in welfare assistance and more than 90 percent of all AFDC families in Maryland received grants in amounts less than $400.

Sexually Transmitted Diseases

Early coital activity heightens the risk of being infected with a venereal disease and a disproportionate number of Maryland youths have been infected. In 1983, 64.5 percent of all reported cases of gonorrhea and 28.6 percent of all reported cases of syphilis occurred in the population 24 years of age and under. Precise breakdowns for persons 19 and under are unavailable. Among the cases where the race of the victim is known, it appears that both gonorrhea and syphilis are more prevalent in the non-white population than in the white population.

Regional Differences

Maryland has often been referred to as an "America in Miniature" because of its geographical diversity. The people residing within its borders are equally diverse. It is well known, even among casual observers, that the incidence of teenage childbearing and childrearing differ

markedly across the State. As could be predicted, those jurisidictions with the highest population density (Baltimore City and Baltimore, Prince George's, Montgomery and Anne Arundel counties) report the highest number of live births and elective abortions.

Baltimore City has consistently reported a high pregnancy rate, birth rate, abortion rate and fetal death rate. Indeed, the incidence of teen parenting in Baltimore City exceeds that reported in any other comparable American City.

Despite steady declines since 1960, the number of births to Baltimore teens is substantially higher than the number reported in any other political subdivision in Maryland. For example, in 1983 Baltimore City reported 3,152 live births to teenagers while Prince George's County, the subdivision consistently ranked second with a population only 15% smaller than Baltimore City, recorded 1,357 live births to teens. Additionally, births to young black women in the City always surpass the number of births to young white women; Baltimore City has by far the greatest concentration of black citizens in the State. In July 1981, 56.4 percent of the total population in Baltimore City was non-white, though non-whites accounted for only 25 percent of the total state population.

Other features specific to Baltimore City are strongly associated with high rates of teenage pregnancy and births. For instance, even though Baltimore City is the smallest geographical subdivision in Maryland, it is by far the most densely populated area. Data from a national survey indicate metropolitan women generally have higher rates of sexual activity and premarital pregnancy than their rural counterparts. School attendance records for September 1982 through June 1983 show substantially higher instances of absenteeism and school withdrawals for Baltimore City than any other region. And while debate continues regarding the sequence of school withdrawal and teen pregnancy, many leading researchers believe that school failure and school withdrawal precede conception among young school-aged women. Nonetheless, consensus confirming a relationship has been established; truncated education is a reliable correlate of teen pregnancy. Poverty, too, is related to teen pregnancy and Baltimore City residents have a per capita income that is appreciably lower than the State average. These single parent households account for the greatest percentage of AFDC families when regional comparisons are made.

In the Eastern Shore area, adolescents under the age of 15 had a birth rate, in 1981, of 2.0 per 1,000 population, a figure which was nearly double that seen for the state as a whole (1.1 per 1,000 population). Birth rates for 15-19 year old adolescents were also higher for Eastern Shore residents than for all Maryland residents (52.0 and 40.7

respectively). Although very young adolescents (below 15 years of age) in Dorchester County showed a particularly high birth rate (6.9 per 1,000 population), one must take into consideration that since only eight infants were born to this maternal age group in 1981, the birth rate is subject to considerable variation, and is less stable than the rates in more densely populated areas.

These data provide a preliminary review of teen pregnancy in Maryland and form the context for the Task Force study.

III. THE TASK FORCE APPROACH

a. Organization of the Task Force

The integral role of key state agencies in understanding and serving teens who are pregnant, parenting, or at risk of becoming pregnant is recognized by the designation of the Secretaries of Human Resources, of Health and Mental Hygiene, and of Employment and Training as ex-officio Task Force members. The Maryland State Department of Education is represented by a member of the State Board of Education; and the State Senate and the House of Delegates each have an ex-officio member on the Task Force. The remaining members are drawn from among state and local community leadership in human services, education, business, and civic affairs.

The Task Force has organized itself into four working subcommittees:

- Subcommittee on the Nature of the Statewide Problem which is studying empirical data about teen pregnancy in Maryland as well as the philosophical context which underlies the issue.

- Prevention Subcommittee which is focusing on primary prevention issues and strategies, that is, intervention prior to an initial pregnancy.

- Support Services Subcommittee which is considering public and private services available to teens after a pregnancy has occurred as well as secondary prevention, that is, delaying or limiting subsequent pregnancies.

- Subcommittee on Interagency Coordination which is exploring the relationships and service gaps among public and private agencies.

While the original nucleus of the subcommittees' membership came from the Task Force, the participation base has been broadened to include representatives from various public and private human services agencies and other significant

community organizations from the local and national level. Additionally, two full-time staff members began work with the Task Force in June.

b. The Task Force Perspective

The Governor's Task Force on Teen Pregnancy reflects a unique approach among states. In October, the Task Force heard testimony from national and local experts which affirms the essential value of addressing the problems and consequences of teen pregnancy in a systematic, comprehensive and deliberate manner. Dr. Slaughter has committed the Task Force to such a process.

Underlying the work of the Task Force is the idea that new and effective possibilities for dealing with teen pregnancy require us to understand not only matters of fact and emotion, but also to engage matters of interpretation. Efforts to reduce the incidence of teen pregnancy in the United States have been based on moral and/or technical grounds. Even the language we use is value-laden--from popular references to "illegitimacy" and "babies having babies" to more clinical characterizations of "premature parenting" and "measures of fetal outcomes among teens". The Task Force is concerned with factual accountings and emotional reactions to teen pregnancy, and also with how we interpret those facts and emotions in defining issues, making decisions, and designing programs for at risk, pregnant, and parenting teens.

Teen pregnancy is not a new problem and the Task Force is not confining its attention to the issue as though it were bound solely by time or circumstance of life. An unplanned, unwanted, out-of-wedlock pregnancy is a manifestation of private and/or public crises which preceded the pregnancy and for which the private and public costs may be long term and exacting. To this end, the Task Force operates with the belief that the reluctance to discuss teen sexuality, openly, must be confronted. To separate sexual development from social or emotional or intellectual or physical growth in a teenager is to deal with only part of a maturing person. The ensuing discussions should be on the broadest of levels and terms and should include parents, children, teachers, clergy, health care personnel, business leaders, human service providers, public officials, scholars, administrators, etc. A primary intent of such interaction would include understanding the factors which lead a teen to make one decision (or non decision) rather than another.

The methods of the formal Task Force study include at least three strategies: there is a formal data collection and analysis process being carried out through standard research

practices; there are meetings to receive and review testimony and reports from local and national experts in theory and action as well as from teens, parents, and interested community groups; and there is a dialogue which has been initiated among Task Force members and staff and various individuals, groups, and organizations concerned with services to youth in Maryland.

c. Task Force Plans and Time Lines

The Task Force is particularly cognizant of the individual and societal costs which are the consequence of teen pregnancy. The need to mobilize and manage all necessary services in a collaborative and effective manner has become increasingly evident. Several guiding principles have emerged from the work of the four Task Force subcommittees:

- A comprehensive plan of action is preferable to focusing on isolated areas or individual programs.
- While at risk, pregnant, and/or parenting teens comprise a primary client group, the overriding orientation is family-centered.
- Although there are some areas of concern which may demand immediate consideration and resolution, there is a commitment to development of a long term strategy.
- Recommendations for policy or program changes should not outpace the capacity of state or local agencies to provide services and to effect changes.
- Systematic and on-going data collection and analyses should be implemented to facilitate the monitoring and evaluation of policy and program initiatives.
- In pursuit of a comprehensive plan, a broadly-based discussion and understanding of the issue of teen pregnancy is necessary.

One of the essential elements of the work of the Task Force has been the development of a data base which provides the empirical and anecdotal information needed by each of the four subcommittees. In order to highlight issues surrounding the nature of the problem, primary prevention, support services and secondary prevention, and interagency coordination as well as to facilitate systematic development of an information base, the Task Force will focus on these four areas in the next four months. An outline of major subcommittee activities and a time line follows.

December - Nature of the Problem

November 15 - Review summary of literature and data profiles

December 3 - Development and circulation of an issue paper: "The Nature and Extent of Teen Pregnancy in Maryland"

Week of December 10 - Series of panel discussions to react to issue paper

December 31 - Revision of issue paper

January - Prevention of Teen Pregnancy

December 31 - Completion of draft report on the nature and (to the extent possible) effectiveness of primary prevention strategies

Week of January 14 - Workshop on prototype prevention strategies with local and national experts

January 31 - Development and circulation of issue paper: "Primary Prevention Strategies in Maryland"

February - Support Services and Secondary Prevention

February 4 - Completion of preliminary reports of health care and infant day care resources and needs

February 8 - Completion of preliminary report of secondary prevention strategies

Week of February 18 - Series of workshops on health care, infant day care, secondary prevention

February 28 - Development and circulation of an issue paper: "Support Services and Secondary Prevention for Pregnant and Parenting Teens in Maryland"

March - Interagency Coordination

March 1 - Completion of preliminary draft of an issue paper: "Interagency Coordination on Teen Pregnancy Services in Maryland"

Week of March 11 - Seminar on interagency collaboration with local and national experts

March 31 - Revision of issue paper

April - Alternative Approaches to the Issues

Week of April 15 - Task Force Retreat to discuss findings and recommendations in the areas of prevention, support services, and interagency coordination

April 30 - Submission of final subcommittee reports to Dr. Slaughter

May - Draft of Final Report

May 15 - Draft of final report completed

May 20 - Distribution to Task Force and subcommittees for review and comment

May 31 - Comments received by Dr. Slaughter

June - Final Report to Governor Hughes

June 21 - Revisions to final report

June 28 - Final report completed and forwarded to Governor Hughes

IV. OBSERVATIONS AND RECOMMENDATIONS

We do not suffer from an absence of scholarly interest or research in the area of teen pregnancy. We do not even encounter much ambiguity or contradiction in the research findings. There is virtually universal agreement among experts in the field on the following statements:

- most teens are inconsistent in their use of contraception if they use it at all
- a large number of teens terminate unwanted pregnancies by abortion
- pre-natal care is likely to be sought late in the pregnancy
- the teen who is at high risk to bear a child before she is 20 years old is often the child or the sister of a teen mother
- most babies born to teens will be born out-of-wedlock
- the pregnant teenager is half as likely to finish school as her non-pregnant counterpart
- pregnant and parenting teens typically experience increasingly limited life options

- if a school drop-out in the high risk category is not pregnant when she drops out of school, she most likely will be within months of leaving school

- babies of high risk teen mothers, i.e., those who are very young or who delay receipt of pre-natal care, predictably suffer a higher incidence of low birth weight and other health problems

- high risk teen mothers will likely be long term welfare recipients.

Yet, even nationally there is much less agreement on what measures might be taken to reduce the incidence of teen pregnancy and at what point a given intervention may best be made. Traditional approaches for responding to problems related to teen sexuality, pregnancy, and parenting have been remedial (after the pregnancy occurs), uncoordinated, inadequate, and undifferentiated as to age or purpose. These statements are also characteristic of Maryland.

While the Task Force is in process of collecting data relative to the nature and extent of teen pregnancy and the actions that might be taken to reduce such problems, certain action areas are already clear:

- The need for a comprehensive data basis which is

  -centrally located
  -accountably maintained by appropriate agencies
  -accessible to institutional users

- The need for interagency coordination which is

  -authentic and workable
  -operating at service and high administrative levels
  -evaluated on outcomes

- The need for comprehensive program designs and services which

  -prevent pregnancy among teens at risk
  -support pregnant and parenting teens
  -have built-in monitoring and evaluation mechanisms

From their preliminary considerations, the Task Force subcommittees are expecting to propose agendas for action which will feature:

- a comprehensive primary prevention model which addresses such matters as values education, family life and human development, family resource services, economic opportunity, and public information.

- a comprehensive support services model which includes prenatal and post-partum health care, family planning, parenting skill development, day care services, outreach services, and support groups, case management methods, and economic independence.

- models of interagency coordination affecting data collection and analysis, policy and program development and service delivery.